

Executive Summary

Protecting the 1.6 million residents in the nation's 17,000 nursing homes is a priority for this Administration and the Health Care Financing Administration (HCFA). In 1995, we began enforcing the toughest nursing home regulations ever, implementing reforms in the Omnibus Budget Reconciliation Act of 1987 (OBRA). These new regulations led to several improvements, including reductions in improper use of anti-psychotic drugs and physical restraints.

In 1997 and 1998, we spent considerable time assessing the effect of the 1995 regulations and considering what changes needed to be made in order to realize more fully the objectives of the OBRA 1987 reforms. We presented our findings to the Congress in a July 1998 Report. We concluded that State-run nursing home inspections were too predictable, with inspectors frequently appearing on Monday mornings and rarely visiting on weekends or during evening hours, allowing nursing homes to prepare for inspections. Several States had rarely cited any nursing homes for substandard care. Nursing home residents were suffering unnecessarily from easily prevented clinical problems such as bed sores, malnutrition, and dehydration. We were also concerned that residents were still experiencing physical and verbal abuse, and neglect.

To address these issues, we launched the President's Nursing Home Initiative (NHI) in July 1998, and have been continually refining and building on it since that time. This report presents preliminary findings on this initiative, and is the first in a series of annual evaluations of the NHI. The NHI was designed to address weaknesses in Federal and State oversight of nursing homes, and includes many ongoing provisions to meet specific goals, such as:

- C Making inspections less predictable and helping States improve the quality of inspections;
- C Quickly investigating complaints alleging actual harm to residents;
- C Cracking down on facilities with repeated violations by making them subject to greater scrutiny and immediate sanctions, and preventing those terminated from Medicare and Medicaid from immediately reentering the programs; and
- C Preventing dehydration, malnutrition, and abuse.

Working with Congress, we have obtained essential support for the NHI. The State survey agencies, which have the primary responsibility for conducting inspections and protecting resident safety, received \$8 million to begin phase in of the NHI activities in FY 1999. For FY 2000, Congress increased funding to the State survey agencies by \$40.5 million for NHI activities. In FY 2001, the President is requesting \$55.4 million for the States for NHI activities. Congress also has increased funding to HCFA and the Department of Health and Human Services to support the NHI. This funding totaled \$7.2 million FY 1999 and \$31.2 million in FY 2000.

It has now been 2 years since the NHI began. Many provisions are still being implemented, and it would be premature to draw definitive conclusions about the impact of various NHI provisions from the limited, preliminary data available to date. There also is substantial variation among States in all measures examined, which could be attributed to any number of different factors including actual differences in quality, case-mix or surveyor practices. This degree of variation suggests that we need to be cautious when comparing results across States, and in Chapter 2 we discuss a number of things we are doing that could possibly address this. That aside, the preliminary findings in this report will establish baseline measures and will help us identify improvements and weaknesses in the survey and certification processes. In addition, more sophisticated analyses of these measures over time will help us understand the causes of change in nursing home resident status and enable us to identify where further efforts are needed.

Summary of Findings

This report is divided into four chapters. The first chapter looks at several of the NHI provisions to see how completely they were implemented by HCFA and the State agencies. The second reviews several measures of survey problem identification, such as the mean number of deficiencies found in a survey, and the proportion of surveys that result in determinations of substandard quality of care, in order to assess indirect evidence that the NHI might have led to changes in surveyors' ability or willingness to detect problems. The third assesses several resident characteristics, such as rates of pressure sores, that may indirectly reflect NHI interventions. The fourth describes several of our consumer education initiatives.

Some NHI policies have been implemented successfully in most States. Data analyses show that:

- State surveyors have nearly reached the goal of conducting 10 percent of such surveys on nights and weekends, and preliminary data from July 2000 indicate that, on a national level, States have met the 10 percent goal;
- State surveyors are identifying more substandard quality of care, with the average number of deficiencies found per survey across all States up from 6.3 in 1996 to 7.0 in 1999, and the percentage nationally of facilities cited for failure to prevent or care for bed sores up from 16.4 percent in 1996 to 17.7 percent in 1999;
- State surveyors also are citing more nursing homes for abuse, with the total up from 6.7 percent in early 1996 to 14.1 percent in 1999;
- More than 90 percent of facilities with severe deficiencies were referred for immediate sanctions; and

- Only 10 of 33 nursing homes involuntarily terminated from the Medicare program in 1999 had been readmitted, and those that were readmitted had remained out of the program an average of five months while they made corrections to come back into compliance.

However, more work is needed to successfully implement other NHI policies.

- Not all States are using a streamlined process for investigating serious complaints. That may be because States and HCFA had different expectations about the policy guidance we would provide, but clearly the guidance we did provide was not sufficient. Nevertheless, more than two-thirds of the States reported that they are investigating complaints alleging immediate jeopardy within 2 days, and 13 States are investigating all complaints alleging actual harm within 10 days.
- While the effort to designate 100 “special focus” facilities (facilities that have shown a pattern of serious, repeated problems) has helped to document and focus States’ efforts to remediate quality problems, some States may not have fully implemented protocols for investigating “special focus” facilities. Nevertheless, 10 percent of these facilities were removed from the Medicare and Medicaid programs or voluntarily withdrew, while another 25 percent improved sufficiently to be considered in substantial compliance.

This report also examines resident characteristics that may indirectly reflect NHI interventions. Use of physical restraints has continued to decline, from 16.3 percent in 1997 to 11.1 percent in 1999. However, data on other measures are mixed and vary by data source (for reasons discussed in chapter three), making it difficult to reach firm conclusions. Conclusions are also limited because of the time periods for which some data are available.

Finally, this report reviews other NHI consumer education efforts. Perhaps the most successful is our award-winning Nursing Home Compare website at www.medicare.gov. It allows consumers to search by zip code or facility name for data on each facility’s care and safety record, staffing levels, number and types of residents, facility ownership, and ratings in comparison to State and national averages. The site is recording 500,000 page views each month and is by far the most popular section of our website. In addition, we have revised our “Guide to Choosing a Nursing Home” booklet and video and have greatly expanded distribution. We have begun national education campaigns to raise awareness of malnutrition and dehydration, resident abuse, and the rights to quality care. And we have tested postcards that allow residents, families, and staff to submit anonymous complaints.

Next Steps

We are committed to continuing to strengthen and build upon the NHI, and we will take several specific additional actions to do so. These include:

- C Continuing to work to increase consistency in the survey process, including examining the current mix of comparative and observational surveys, and improving interactions between our Regional Offices and State survey agencies;
- C Developing and requiring continuing education for surveyors to bring consistency in how different deficiencies are categorized, and requiring periodic recertification of surveyors;
- C Examining how to make optimal use of available remedies and the possible need for additional authorities;
- C Implementing Standards of Performance for State survey agencies to provide a consistent basis for evaluating and comparing the performance across States;
- C Directing our 10 Regional Offices to periodically prepare 18 “tracking” reports on areas that measure both State and Regional Office performance, such as pending nursing home terminations and Online Survey, Certification, and Reporting System (OSCAR) data entry timeliness;
- C Requiring States that did not meet the 10 percent goal for off-hour surveys to provide written plans on how they will meet the goal in the next year; and
- C Refining data systems to increase reliability and allow better linkages between data sources, greater insights into variations, more timely access, and easier conversion to consumer-friendly formats.

We also will continue efforts to address the link between staffing levels and quality of care. We recently published preliminary findings that demonstrated, in a statistically valid way, that there is a clear relationship between staffing levels and quality of care, with significantly more problems in facilities with less than 12 minutes of registered nursing care, less than 45 minutes of total licensed staff care, and less than 2 hours of nursing aide care per resident per day. The troubling results suggest that many facilities may need to increase staffing levels. We are now working to expand and further validate our research, refine ways to adjust minimum staffing requirements for the types of patients in a given facility, and determine the costs and feasibility of implementing minimum staffing requirements.

The President has proposed legislation authorizing incentive grants to help States explore innovative ways to raise staffing levels. The proposal also includes enhanced reporting requirements on staffing levels and a commitment to develop minimum staffing regulations. We will work with Congress to secure passage of this important legislation.

Conclusion

States have generally implemented the NHI in ways that should lead to improvements in oversight and quality of care. There have been substantial increases in staggered surveys, a rise in citations for quality problems, and reductions in use of restraints. More work is needed in specific areas, such as implementing speedier complaint investigations. We are committed to continuing to work with residents and their families, advocacy groups, providers, States, and Congress to ensure that the NHI is fully and effectively implemented and that nursing home residents receive the quality care and protection they deserve. We greatly appreciate the additional support Congress has provided for the NHI, and the cooperation we have received from States, resident advocates, and nursing home providers. With continued cooperation and support, we are confident that the NHI will succeed in its goal to improve oversight and the quality of care for nursing home residents.

Introduction

This is the first of a proposed series of annual reports evaluating the effect of the President's Nursing Home Initiatives (NHI) on quality of care. It examines nursing home resident characteristics and care outcomes, and provides preliminary findings in response to a request by the Senate Appropriations Committee.¹ This report provides an update of the Health Care Financing Administration's (HCFA's) activities and will describe HCFA's strategy for building upon the NHI and ensuring that it is implemented effectively by the States.

Some 1.6 million elderly and disabled people receive care in approximately 17,000 nursing homes across the United States. The Federal government provides funding to States to conduct on-site inspections and recommend sanctions for violations of health and safety rules by facilities participating in Medicare and Medicaid. State Medicaid programs fund care for approximately two-thirds of nursing home residents, and Medicare finances care for about 10 percent. We are committed to working with residents, their families, advocacy groups, providers, States, and Congress to fully and effectively implement the President's NHI.

Public concern about the quality of care in nursing homes and about the ability of the Federal and State system of survey and certification to protect vulnerable residents continues. Protecting nursing home residents is a priority for our Agency and this Administration. In 1995, we began enforcing the nation's toughest-ever nursing home regulations. These regulations brought about measurable improvement, as documented in our 1998 Report to Congress "*Study of Private Accreditation (Deeming) of Nursing Homes, Regulatory Incentives and Non-regulatory Initiatives, and Effectiveness of the Survey and Certification Process*," (1998 Report to Congress). However, the report and investigations by the General Accounting Office (GAO) made clear that more needed to be done. President Clinton, therefore, announced this major new initiative to increase protections for vulnerable nursing home residents and to crack down on problem providers in July 1998.

In the latter half of 1998 and throughout 1999, HCFA implemented a number of new survey and enforcement activities. These activities included the selection of a group of nursing homes (the so-called Special Focus Facilities) to receive close scrutiny by State survey agencies; the initiation of a standardized process for handling complaints; new emphasis on conducting surveys outside of normal business hours; and, closer scrutiny of potential problems of care related to pressure ulcers (sores), use of physical restraints, dehydration, and nutrition. While some of these initiatives have only been recently implemented, we have begun to assess the current status of these efforts.

¹ Page 199 of Senate Report 106-166 (accompanying the FY 2000 Labor, HHS, Education appropriation bill).

Overview of the Contents of this Report

This report reviews selected activities that are a part of the NHI and factors that may be impacted by the NHI in order to assess our progress and help identify areas where further efforts may be needed. We believe the evidence thus far suggests that we are moving in the right direction to improve quality of care. However, we are still in the early stages of implementing the NHI, and thus, we have tried to be cautious in making inferences about the causal impact of the NHI. The report findings are grouped into four areas.

Chapter 1 examines implementation of NHI initiatives that had very specific process objectives. It reviews: 1) implementation of a staggered schedule for nursing home recertification surveys; 2) giving facilities with a history of noncompliance no opportunity to correct before imposition of enforcement remedies; 3) allowing reasonable assurance periods before re-admitting terminated nursing homes to the Medicare program; 4) increased scrutiny of special focus facilities; and, 5) implementing a streamlined process for investigating complaints in which allegations were raised.

Chapter 2 examines data reported by States on results of nursing home inspections to identify whether the number and types of deficiencies cited has changed. These data include: 1) the number of health deficiencies found; 2) the number of citations for resident abuse; 3) the number of citations for improper use of physical restraints; 4) the number of citations for pressure sores; 5) the number of findings for substandard quality of care; and, 6) the number of surveys that found no deficiencies. We are not at this time able to separate the impact of other factors or to assess the appropriateness of any individual nursing home survey, but we can compare the results found here to findings in our 1998 Report to Congress about how well the nursing home survey process identified problems in nursing homes.

Chapter 3 assesses changes in resident characteristics related to quality of care and targeted by the NHI. They include the prevalence of physical restraint use, pressure sores, tube feeding, dehydration, and weight loss.

Chapter 4 describes NHI efforts to help educate consumers about choosing a nursing home, such as establishment of the Nursing Home Compare website, and publishing a guide and video on choosing a nursing home. We also have begun educational campaigns about specific problems some nursing home residents encounter--malnutrition and dehydration, and abuse and neglect. In addition, though not a part of the President's NHI, at the suggestion of consumer representatives, we also tested the use of postcards intended to give nursing home residents, their families, and nursing home staff the opportunity to send in anonymous comments to HCFA.

There also are appendices describing the history of nursing home enforcement and the Nursing Home Initiative, the NHI budget, State-specific data charts, and other information.

Data Sources

This study presents preliminary data from the Online Survey, Certification, and Reporting System (OSCAR) and from the Minimum Data Set (MDS). OSCAR includes data reported by the nursing homes, at the time of the annual survey, on resident characteristics, on nursing home staffing, and on resident census. OSCAR also contains information on citations made by State surveyors for regulatory violations uncovered during the survey. State agencies input new survey data on an ongoing basis, and are not constrained to entering the data at certain periods (such as at the end of the month or calendar quarter). As a result, OSCAR is updated continuously and the data stored within it can change daily.

Unless otherwise noted, when analyzing OSCAR data, the data were downloaded from OSCAR on April 1, 2000 for CY 1999 and earlier. This was done to establish consistency within this report, and the April 1 date will be used to collect data for subsequent annual reports, creating a standard 12-month interval for collecting and reporting data.

The MDS is a longitudinal data set that captures clinical information about nursing home residents in every Medicare- and Medicaid-certified nursing home in the country. It is estimated that these homes represent more than 95% of all nursing homes in the country. We have collected MDS data from the States since July 1998.

Study Context

These data can begin to illustrate broad trends that are potentially affected by the NHI. However, it is inherently difficult to give a definitive assessment of the effectiveness of an initiative like the NHI. The criterion for judging the effectiveness of the NHI in bringing about improvements in quality of care is not obvious. In general, improved regulation may be regarded as a blunt instrument for improving the quality of care. Our current system, like many regulatory systems, is designed to ensure minimal standards of care. Hence, while improvement in the survey and certification system might raise the performance of poorly performing facilities, it may not have any impact on those nursing homes that perform above that minimum. Other NHI consumer and provider initiatives may, in the long-term, have their own effect on quality of care.² For example, through competition and full disclosure, the Nursing Home Compare website could motivate nursing homes to improve performance. Similarly, the Nutrition Awareness Campaign, as well as our Sharing Innovations in Quality website for providers, could improve care by educating consumers and providers on the symptoms as well as best practices associated with malnutrition, dehydration, pressure sores, abuse, and other issues.

²However, although these non-regulatory initiatives are attractive and provide useful information to consumers, these interventions have not been formally evaluated for their ability to lead to improvement in quality of care.

Without a randomized study design or even a quasi-experimental design³, we cannot ultimately separate the effects of the NHI from other concurrent changes, such as implementation of the Medicare Prospective Payment System (PPS) for Skilled Nursing Facilities, financial difficulties experienced by some large chains and individual facilities, decline in occupancy levels, changes in the acuity and functional limitation of residents, and changes in practice patterns. In addition, the NHI is not a single intervention, but a package of interventions implemented at varying times and to varying degrees. If determining the collective impact of the NHI is difficult, assessing the effect of a specific intervention is even more challenging. Subsequent reports, which will have the benefit of additional data sources, may provide better evidence of causal association.

Moving Forward

We believe that this report's findings demonstrate that our oversight of State agencies needs to be strengthened further. We recently promulgated Standards of Performance for State survey agencies and advised them that we will take action if they fail to meet those standards. We are exploring the resource implications of conducting more comparative surveys versus observational surveys.⁴ And we want, in future studies, to examine the effectiveness of different types of enforcement penalties, especially in instances where an immediate enforcement response is indicated.⁵

³A randomized study design is not possible after the fact, but a quasi-experimental design, which takes advantage of the observation that States implemented the NHI to different degrees and at different time periods, could be used in the future to test the association between the degree of implementation of the NHI and changes in nursing home resident characteristics.

⁴Comparative surveys are those in which Federal surveyors conduct an independent survey within 60 days of a State's survey of a nursing home. Observational surveys are those in which Federal surveyors accompany State surveyors and observe the actual State survey.

⁵The choice of sanctions for this level of noncompliance is either a civil money penalty (CMP) or a denial of payment for new admissions. Other sanctions may also be imposed. Although nursing homes have the right to pay CMPs immediately in return for a 35% reduction in the amount of the penalty, many nursing homes have chosen to appeal their monetary sanctions through the Department's administrative process. Because CMPs may not be collected until after the facility either goes through the appeals process or waives its right to appeal, the sanction is not immediate. The President recently announced a legislative proposal that will immediately impose CMPs. Recent attention has been paid to the backlog of enforcement cases at the Departmental Appeals Board associated with the Nursing Home Initiative and other program enforcement activities. HCFA is currently working with the Departmental Appeals Board and other parts of the Department of Health and Human Services on a number of proposals we hope will address this issue. In addition, the denial of payment for new admissions can be an effective sanction that can be imposed with a minimum of 15 days' notice to the nursing home. Unlike CMPs, the appeal occurs after the sanction has been imposed. By law, HCFA and the States must impose this sanction at the third month if a nursing home continues to be out of compliance with Federal requirements. This penalty, however, may be imposed before three months elapse. HCFA issued revised instructions to the States and Regional Offices in January 2000 that encouraged the use of the denial of payment for new admissions sanction sooner when appropriate. We will continue to monitor compliance with those instructions, although the downside of using this sanction is that once a denial of payment for new admissions is imposed, the nursing home loses its ability to conduct nurse aide training. Ultimately, other than the mandatory sanctions established by law, the choice of enforcement sanctions is up to the State.